U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 16 July 2007

CASE NO.: 2004-BLA-6244

In the Matter of:

J. M.
Claimant

v.

MEADOW RIVER COAL COMPANY
Employer

and

WEST VIRGINIA COAL WORKERS' PNEUMOCONIOSIS FUND
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

DECISION AND ORDER ON REMAND-AWARDING BENEFITS

This proceeding arises from a claim for compensation under the Black Lung Benefits Act and was heard by the undersigned in Beckley, West Virginia on July 20, 2005. On December 30, 2005 I issued a Decision and Order-Awarding Benefits. The employer appealed to the Benefits Review Board which issued a Decision and Order on November 27, 2006 affirming in part, vacating in part, and remanding the case for further consideration. On December 18, 2006 the employer filed a Motion to Reopen the Record. I issued an Order Denying Employer's Motion to Reopen the Record and Setting Briefing Schedule on June 11, 2007 giving the parties until July 11, 2007 to file briefs. Claimant and employer have filed timely briefs.

In its Decision and Order, the Board agreed with the employer's contention that I had based my determination that the miner has pneumoconiosis solely on the radiographic evidence and had not adequately reviewed each of the physicians' opinions in regards to whether or not they supported a finding of pneumoconiosis apart from the radiographic evidence. The Board remanded the case for reconsideration of the evidence at 20 CFR § 718.202(a)(4) and for a reweighing of all the evidence pursuant to § 718.202(a). Because the Board required me to reevaluate whether the x-ray and medical opinion evidence together is sufficient to establish the

existence of pneumoconiosis, the Board also vacated my finding that the miner is totally disabled due to pneumoconiosis.

Pertinent Facts

Dr. D. L. Rasmussen examined the miner on July 14, 2003. (DX 10). Dr. Rasmussen recorded a cigarette smoking history of two packs a day from 1957 to 1972 and he credited the miner with thirty three years of coal mine employment of which twelve years were in underground mines. The pulmonary examination was normal and the miner's chest x-ray was classified as 1/1, t/t. The miner's pulmonary function studies were normal but the blood gas tests indicated a moderate impairment in oxygen transfer during light exercise. Dr. Rasmussen diagnosed coal workers' pneumoconiosis, chronic bronchitis, arteriosclerotic heart disease, and sleep apnea. He concluded that the miner does not retain the pulmonary capacity to perform his last regular coal mine job, and that coal mine dust exposure is a major contributing cause of his disabling lung disease. Dr. Rasmussen noted that the miner has a significant history of coal mine dust exposure and x-ray changes consistent with pneumoconiosis, and that it is medically reasonable to conclude that he has coal workers' pneumoconiosis which arose from his coal mine employment. Dr. Rasmussen further stated that the primary risk factor for the miner's disabling lung disease is his coal mine dust exposure, and that although his cigarette smoking contributed to his pulmonary impairment his impairment in gas exchange and not ventilatory capacity is commonly observed in impaired coal miners.

The miner was evaluated by Dr. George Zaldivar on October 27, 2003. (DX 11). Dr. Zaldivar determined that the miner had thirty three years of coal mine work of which twelve to fifteen years were underground, and that he had smoked one and one half to two packs of cigarettes a day from age eighteen (1958) to thirty five years ago (1968). In the pulmonary examination, the miner's lungs were clear to auscultation without wheezes, crackles, or rales. The miner's chest x-ray was negative for pneumoconiosis, the exercise test, spirometry, and lung volumes were normal, and there was a mild diffusion impairment. Dr. Zaldivar concluded that there is no evidence to support a diagnosis of coal workers' pneumoconiosis and that the miner does not have a pulmonary impairment.

Dr. Rasmussen was deposed on April 26, 2005. (CX 2). He testified that the miner exhibited the typical impairment frequently seen in coal miners, i.e., a significant impairment in gas exchange and normal ventilatory function. Id at 8. Two potential causes of the miner's pulmonary impairment are his previous cigarette smoking and his exposure to coal dust. Id. He showed none of the signs expected from cigarette smoking, i.e., airway reduction with a reduced FEV1 and a reduced FEV1/FVC, but he did exhibit impairment in gas exchange during exercise. Id. Dr. Rasmussen diagnosed clinical and legal pneumoconiosis and concluded that the miner suffers from a totally disabling pulmonary impairment as a result. Id at 15. The miner's cigarette smoking makes a minor contribution to his pulmonary impairment. Id at 17. His chronic bronchitis did not contribute to his pulmonary impairment as there is no evidence of airway obstruction. Id.

Dr. Boustani's medical opinion was neither documented nor well reasoned and was previously found entitled to little weight.

Conclusions of Law

Section 718.202(a)(1)-(4) provides that the existence of pneumoconiosis may be established by chest x-rays, biopsy or autopsy evidence, the presumptions in §§ 718.304, 718.305, or 718.306, or the reasoned medical opinion of a physician, exercising sound medical judgment, that the miner suffers from pneumoconiosis as defined in § 718.201.[1] All of the relevant medical evidence must be weighed in determining if the existence of pneumoconiosis has been established. *Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 22 BLR 2-162 (4th Cir. 2000). There is no biopsy or autopsy evidence and the above-noted presumptions are not applicable to this case.

The record includes four interpretations of the July 14, 2003 x-ray, one interpretation of the October 27, 2003 x-ray, and two interpretations of the February 4, 2004 x-ray. The July 14, 2003 x-ray was read as positive for pneumoconiosis by Dr. Patel, a board certified radiologist/B reader, and Dr. Rasmussen, a B reader, and negative for pneumoconiosis by Dr. Binns, a board certified radiologist/B reader. As a preponderance of the interpretations of the July 14, 2003 x-ray is positive for pneumoconiosis, I find that it is a positive x-ray. Dr. Zaldivar, a B reader, was the only physician to read the October 27, 2003 x-ray, and he concluded that it is negative for pneumoconiosis. The October 27, 2003 x-ray is therefore a negative x-ray. The February 4, 2004 x-ray was interpreted as positive for pneumoconiosis by Dr. Miller and Dr. Cappiello, both board certified radiologists and B readers. There are no negative readings of this x-ray and it is therefore deemed a positive x-ray. As two of the three x-rays are positive for pneumoconiosis, the x-ray evidence supports a finding that the miner has pneumoconiosis.

Dr. Rasmussen concluded that the miner has both clinical and legal pneumoconiosis. Dr. Zaldivar stated that there is no radiographic evidence of pneumoconiosis or of any dust disease of the lungs. In addition to the miner's coal mine employment history and positive x-ray interpretations, Dr. Rasmussen relied on the pattern of the miner's respiratory impairment, i.e., that the miner had a significant impairment in gas exchange and normal ventilatory function which he found to be typical of impaired coal miners. Dr. Rasmussen's opinion is well reasoned and documented as he considered the miner's occupational history, chest x-rays, and the pattern of his respiratory impairment. Dr. Zaldivar's conclusion that the miner does not have pneumoconiosis is both inconsistent with the preponderance of the x-ray evidence and poorly reasoned as he did not provide any reasons for his conclusion other than his negative x-ray reading. Dr. Rasmussen's opinion that the miner has pneumoconiosis is consistent with the x-ray evidence and well reasoned, and Dr. Zaldivar's opinion is inconsistent with the x-ray evidence and not well reasoned. I accord more weight to the opinion of Dr. Rasmussen.

After weighing the x-ray and medical opinion evidence, I find that the miner has clinical and legal pneumoconiosis.

[1] Section 718.201 defines pneumoconiosis as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairment arising out of coal mine employment. The definition includes both medical or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

Section 718.204(c)(1) states that a miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's total disability if it: (i) has a material adverse effect on his respiratory or pulmonary condition; or if it (ii) materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

Dr. Rasmussen provided a well reasoned opinion finding that the miner's pneumoconiosis is the major contributing cause of his disabling lung disease. Dr. Zaldivar maintained that the miner is not totally disabled due to pneumoconiosis, but as Dr. Zaldivar did not diagnose either clinical or legal pneumoconiosis his opinion on etiology is entitled to very little weight. *Scott v. Mason Coal Co.*, 289 F. 2d 263 (4th Cir. 2002). I rely on Dr. Rasmussen's well-reasoned opinion and I find that the miner is totally disabled due to pneumoconiosis.

IT IS ORDERED THAT Meadow River Coal Company and the West Virginia Coal Workers' Pneumoconiosis Fund:

(1) Pay the miner all the benefits to which he is entitled, augmented by one dependent, beginning as of May 1, 2003;
(2) Pay the miner all the medical benefits to which he is entitled beginning as of May 1, 2003;
(3) Reimburse the Black Lung Disability Trust Fund for interim payments made to the miner; and
(4) Pay interest on the unpaid benefits to the Black Lung Disability Trust Fund.

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DANIEL L. LELAND
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).